ROOT CAUSE ANALYSIS PROCEDURES

PURPOSE

Root Cause Analysis (RCA) is intended for the systematic evaluation of negative incidents. The RCA is used to improve the quality of services and supports for the people we serve. RCAs are intended only for sentinel events that could not be resolved through completion of an internal clinical treatment review. We are amending our RCA process such that instead of the DHHS imposing a seemingly cumbersome, state-run RCA procedure, we are now asking LME-MCOs to conduct their own RCAs and submit essential findings (usually two pages or less) upon completion.

CRITERIA FOR COMPLETION OF ROOT CAUSE ANALYSES

Some sample incidents that may require an RCA include but are not limited to the following:

- Deaths from other than natural causes that occur while someone is in a housing slot and part of supportive housing. (for all deaths, LME-MCO must follow IRIS rules)
- Loss of housing that results in homelessness
- Return to ACH or request for initial admission to an ACH (regardless of the individual's choice to move) post-transition to a housing slot
- Multiple (3+) psychiatric hospital admissions within a year
- Unaccounted-for absence of an individual from the housing unit for 72 hours or more that may or may not require police contact (e.g. silver alert). There is no specified waiting period for reporting a missing person in NC although it is recommended that a missing persons report be filed within the first 24 hours to increase the chances of locating an individual. Waiting 72 hours would allow ample time to allow for a missing persons report and if possible a silver alert to be filed OR for the individual to be located.
- Legal incidents that involve a report to law enforcement for serious criminal activity (felony charges) or a potentially serious threat to the health or safety of self or others, such as assault or rape

RESPONSIBILITIES

LME-MCO

LME-MCO will report, via secure email, all incidents meeting criteria above to the DHHS Special Advisor on ADA in the Office of the Secretary (Jessica Keith – jessica.l.keith@dhhs.nc.gov), with a copy to the DHHS community mailbox (community@dhhs.nc.gov), within **24 hours** of learning about the occurrence. In addition, the LME-MCO will ensure that the required reporting to the NC Incident Response Improvement System (IRIS) is completed within the established timeframe per DHHS guidelines (see Incident Response and Reporting Manual – February 2011 if applicable.

LME-MCO shall conduct a Root Cause Analysis within **seven days** of notification to DHHS for all incidents that meet criteria for a root cause analysis. Final Root Cause

Analysis summary shall be submitted to DHHS Community Mailbox within **five business days** from the date that the Root Cause Analysis review was conducted.

DHHS

DHHS will review the RCA summary submitted by the LME-MCO. DHHS will submit a response to the LME-MCO indicating that the summary submitted is either sufficient or insufficient. If insufficient, DHHS will request any additional information necessary to gain a full picture of the proximal and distal root causes of the event and lessons learned related to the identified causes. If sufficient, DHHS will then share the final report with the Independent Reviewer for the DOJ. Compliance with action plans from the "lessons learned" section, if applicable, will be monitored through the intradepartmental monitoring team meetings.

DMH/DD/SAS is available for technical assistance for the root cause analysis process. Additional recommendations for the process are also included below.

REQUIRED ELEMENTS OF A RCA (TEMPLATE REPORT ATTACHED)

Although LME-MCOs are welcome to use the attached template, this particular format is not required. The elements described below must be present in whatever format the LME-MCOs offer.

- **Justification of the Root Cause Analysis**. This is a brief and succinct statement of the problem or description of the incident that prompted the need for a Root Cause Analysis.
- **Identified Root Cause(s).** This is a list of the proximal and distal causes of the incident; the issues that are central to the incident. It is very important not to blame the individual when identifying the root causes. Rather than saying that the root cause was that the individual did not adhere to medication recommendations, it may be that the Person-Centered Plan did not have enough supports built in to ensure the individual took his/her medicine regularly.
- **Lessons Learned/Action Plan.** This is a list of future actions that is directly related to the identified causes. It must be detailed and situation-specific such that it serves as an action plan for either decreasing the probability that the incident will recur or sets out measures the responsible party can implement with other individuals that will decrease the probability of a similar incident occurring with other individuals.

MINIMUM RCA PARTICIPANTS

Minimum RCA Participants

- Transition Coordinator
- Care Coordinator (if applicable)
- Community Provider(s)
- Tenancy Support Staff

INTERNET RESOURCES FOR THE RCA PROCESS

https://www.ohanaccs.com/WCAssets/hawaii/assets/hi_medicaid_behavorial_steps_root_cause_analysis_form_10_2012.pdf
http://www.magellanofpa.com/media/229862/rcas_and_action_planning_oct_2012.pdf
http://www.jointcommission.org/Framework_for_Conducting_a_Root_Cause_Analysis_and_Action_Plan/
http://pb.rcpsych.org/content/28/3/75
http://ajp.psychiatryonline.org/data/Journals/AJP/3885/09aj0372a.PDF
http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60181
http://www.hsri.org/files/uploads/publications/QF_**RootCauseAnalysis**.doc

RCA Summary Template

Date of Report: _____

LME-MCO: _____

Date LME-MCO learned of occurrence: _____

Date of RCA meeting: _____

LME-MCO Staff present: _____
_____
_____

Community Provider
Staff Present: _____
_____
_____

Justification of the Root Cause Analysis (Who, What, When)

Example:
LME-MCO TCLI individual was involved in a legal incident that occurred offsite of the housing unit. Individual became incarcerated on (date) for robbery with a dangerous weapon.

Identified Root Cause (Why)

Example:

1. Natural support and ACT Team identified in the PCP was not adequate to:
    - Monitor nor ensure individual was compliant with medications
    - Ensure that individual was not abusing alcohol or other substances
    - Ensure individual attended the SAIOP program
    - Manage his money (brother was the payee)
2. The original transition plan addresses the individual's SA diagnoses and it mentions his previous criminal history. The crisis plan in the PCP has no goals that address either alcohol or other substance abuse or the criminal history.

Lessons Learned/Action Plan

Example:

1. An individual with an extensive history such as multiple ED visits, non-compliance with medications, serious criminal background must have services

that are “front-loaded”, meaning very intensive in the beginning, to address all critical needs, and then moderated as progress is noted.

2. Closer monitoring of payee is needed to ensure money is being managed appropriately. Work with payee and individual on an agreed upon budget.
3. All critical treatment and other needs must be identified in the PCP to ensure individual is receiving appropriate services. Explore other service options to address substance abuse and legal issues. Seek advocacy for MH court for current legal issues.

cc: Stacey Lee, DMH/DD/SAS
Ken Edminster, DMH/DD/SAS
Martha Are, DAAS
Stacy Smith, DMH/DD/SAS
Walt Caison, DMH/DD/SAS
Beverly Bell, DMA
DMA Contract Manager
Jessica Keith, DHHS, Special Advisor on ADA
Lisa Corbett, DHHS, Assistant General Counsel
Kathy Nichols, DMA, Lead Waiver Program Manager, Contracts Section
Sandee Resnick, DMH/DD/SAS, Accountability Section Chief
Mabel McGlothlen, DMH/DD/SAS, System Performance Section Chief